(18)

No. 90-97

In The

Supreme Court of the United States

October Term, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner,

vs.

NATIONAL LABOR RELATIONS BOARD, ET AL.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

AMICUS CURIAE BRIEF OF THE GREATER CINCINNATI HOSPITAL COUNCIL IN SUPPORT OF THE AMERICAN HOSPITAL ASSOCIATION, PETITIONER

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SUMMARY OF ARGUMENT

1. The National Labor Relations Act Prohibits The Use Of Formal Rules In Bargaining Unit Determinations

Section 9(b) of the National Labor Relations Act, 29 U.S.C. § 159(b), requires that the National Labor Relations Board make bargaining unit determinations "in each case." The plain meaning of this term requires that the Board consider each case individually. The legislative history of Section 9(b) stresses that bargaining unit determinations depend upon the facts of each particular case. Subsequent legislative actions have not modified the need for individualized bargaining unit determinations. The Board erred in issuing bargaining unit rules in reliance upon this Court's opinions in *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759 (1969) and *Heckler v. Campbell*, 461 U.S. 458 (1983).

2. Establishing Bargaining Units By Rulemaking Will Make The Health Care Industry Less Effective And Efficient

The adoption of bargaining unit rules by the Board will seriously hamper the ability of hospitals to evolve and adapt in their efforts to provide effective and efficient health care. The "extraordinary circumstances" exception found in the instant rules is a sham which will not allow hospitals the opportunity to have their own particular circumstances considered.

3. The Creation Of Eight Hospital Bargaining Units By Rulemaking Is Arbitrary And Capricious

In *Motor Vehicle Manufacturers Association v. State Farm Mutual Automobile Insurance Co.*, 463 U.S. 29 (1983), this Court concluded that an agency rule would be found arbitrary and capricious if the agency failed to consider an important aspect of the problem or offered explanations for its decision that were either contrary to evidence or implausible.

The Board's proposed bargaining units for registered nurses and physicians are contrary to the facts determined by the agency and, further, are wholly implausible. The Board concluded that registered nurses should have their own bargaining unit primarily because they were, in the agency's view, "unique." The facts asserted in support of this conclusion are inconsistent, contradictory and implausible. The agency seeks to segregate registered nurses from other professionals, when the agency's own findings reveal that registered nurses work in close coordination with other professionals and are part of an overall complex web of patient care.

The arguments that the Board puts forth for separating physicians can be advanced just as strongly on behalf of every identifiable professional group within a hospital. No basis has been articulated upon which physicians (or registered nurses) should be treated any differently than occupational therapists, laboratory technologists or pharmacists.

With respect to skilled maintenance bargaining units, the Board relies upon factors which utterly fail to distinguish these employees from any other employees. The

Board's real motive in permitting a skilled maintenance unit was to cater to the organizational interests of a particular group of labor organizations.

ARGUMENT

I. INTEREST OF AMICUS CURIAE

The Greater Cincinnati Hospital Council (hereinafter referred to as "GCHC") is an association with its headquarters in Cincinnati, Ohio. The GCHC consists of 34 member institutions, 26 of which are "acute care hospital[s]" as defined in the National Labor Relations Board's Final Rule for Collective-Bargaining Units in the Health Care Industry, 29 C.F.R. 103.30(f)(2), 54 Fed. Reg. 16347-48 (hereinafter referred to as the "Rule"). The GCHC opposes the Rule adopted by the National Labor Relations Board (hereinafter referred to as "the Board"), because it is firmly convinced that the implementation of the Rule would severely and adversely impact the ability of GCHC members to provide health care services to the inhabitants of the Greater Cincinnati area.

II. THE NATIONAL LABOR RELATIONS ACT PROHIBITS THE USE OF FORMAL RULES IN BARGAINING UNIT DETERMINATIONS

A. The Language Of The Statute Mandates Individualized Decision-Making

The language of Section 9(b) of the National Labor Relations Act (hereinafter "the Act"), which has remained unchanged since 1935, states in relevant part:

> The Board shall *decide in each case* whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by [the

> National Labor Relations Act], the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof . . . .

29 U.S.C. § 159(b) (emphasis added).

The term "decide in each case" has a clear and obvious meaning. The ordinary meaning of the word "each" is to consider "individually or one by one . . . ." *Random House Dictionary of The English Language* 612 (2nd Ed., Unabridged 1987). The Board is statutorily instructed to decide in each case, "one by one," the appropriate unit in light of the circumstances existing in each individual case. Had Congress omitted the words "in each case," the Board would perhaps be free to "decide" bargaining unit issues in advance by means of rules; however, by directing the Board to examine each case individually before deciding upon appropriate units, Congress foreclosed rulemaking as a means of bargaining unit determination. "[O]f course, no deference is due to agency interpretations at odds with the plain language of the statute itself." *Public Employees Retirement System of Ohio v. Betts*, ___ U.S. ___, 109 S.Ct. 2854, 2863 (1989)

B. The Legislative History Of Section 9(b) Strongly Reflects Congressional Intent That The Board Examine Each Individual Case Before Determining Appropriate Bargaining Units

Labor representatives argued in 1935 that employees themselves should make unit determinations. Hearings on S. 1958 Before Senate Committee on Education and Labor, 74th Cong., 1st Sess. (1935), reprinted in *Legislative History of the National Labor Relations Act 1935*, at 1679 (hereinafter *"1935 Leg. Hist."*). Firmly rejecting that approach, Senator Wagner stated:

> Now, somebody must decide. Supposing there is a dispute . . . [and] then we have an election to decide who represents the workers. How is the election to be held? Somebody must decide whether the workers in all three plants vote as one, or whether each plant votes separately, or whether there are different crafts which do not relate to one another, where the workers in one craft do not know the problems of the workers in the other craft . . . . Somebody must decide it, and that is given as a governmental function to decide.

Id., 1935 Leg. Hist., at 1819-20.

The Senate Report to S. 1958 explained that the Board was empowered, under Section 9(b), to determine appropriate units, because

> [o]bviously, there can be no choice of representatives and no bargaining unless units for such purposes are first determined. And employees themselves cannot choose these units, because the units must be determined before it can be known what employees are eligible to participate in a choice of any kind.

S. REP. No. 573, 74th Cong., 1st Sess. (1935), *1935 Leg. Hist.*, at 2313.

The originally proposed language of Section 9(b) simply stated: "The Board shall decide whether . . . . " Proposed Amendments to S. J. Res. 143 (1934), *1935 Leg. Hist.*, at 1173. The words "in each case" were inserted after "decide" in the final version. As Senator Walsh stated, "[t]he appropriate unit depends so much upon the facts of *the particular case* that necessarily the Board must

determine the unit . . . . " Debates on S. 1958 in Senate, 74th Cong., 1st Sess. (1935), *1935 Leg. Hist.*, at 2391 (emphasis added). The House Report on the parallel bill also noted that the matter of unit determination "is obviously one for determination *in each individual case* . . . . " H. R. Report No. 969 (House Committee on Labor Report to Accompany H.R. 7978), *1935 Leg. Hist.*, at 2930 (emphasis added). The same explanation is found in House Report No. 972 on S. 1958 (*1935 Leg. Hist.*, at 2976) and in House Report No. 1147 on S. 1958 (*1935 Leg. Hist.*, at 3072). Thus, both the plain language of Section 9(b) and the legislative history of the 1935 Act set forth the clear intent of Congress that, because of the unique facts presented by each different employment setting, the Board must determine the appropriate bargaining unit *in each case*.

In the decision below, the court of appeals erroneously reasoned that the term "in each case" was added to Section 9(b) for only one reason:

> [T]o prevent the Board from bringing about a revolution in unit determinations by prescribing employer units, or craft units, or plant units for all employers under the Board's jurisdiction.

American Hospital Association v. NLRB, 899 F.2d 651, 656 (7th Cir. 1990). The appellate court went on to note that the two major labor federations, the AFL and the CIO, had been battling over precisely that issue. The court concluded that the "in each case" proviso had been added in order to forbid the Board from altering "the balance of power" between the labor federations. *Id.*

The appellate court's analysis badly missed the mark. If the proviso was added solely to prevent the Board from

directing that a particular form of bargaining units be prescribed for a particular category of employer, that prohibition would serve just as well to bar the Board from issuing the instant Rule. In essence, the Board has issued a rule prescribing certain types of "craft" units for hospitals, e.g., registered nurses, physicians, and skilled maintenance workers. Thus, if the phrase "in each case" was meant to bar the Board in 1935 from mandating, for example, that only craft units would be permitted in a particular manufacturing industry, that prohibition would have equal force in the present situation. The Rule that the Board seeks to implement is fundamentally contrary to that asserted legislative purpose. We submit that the phrase was added for a broader purpose – that is, to ensure that bargaining unit determinations take into account all of the factual differences that exist between one employment setting and another.

The legislative history of Section 9(b), therefore, is quite clear. The Board must decide each individual case on its own merits, after examining the particular facts of each situation. The language of Section 9(b) is equally clear: "[T]he Board shall decide in each case . . . . " This language is mandatory, not permissive; therefore, the Board may not evade its statutory duty by predetermining appropriate units.

C. Subsequent Legislative Actions Have Not Altered The Requirement Of Individualized Unit Determinations

A proviso to Section 9(b) was added by the Labor Management Relations Act in 1947, but the original language of Section 9(b) remained unchanged. The

accompanying Senate Report noted that the "bill still leaves to the Board discretion to review all the facts in determining the appropriate unit." SEN. REP. No. 105, 80th Cong., 1st Sess. 12 (1947). As is apparent, all the facts relevant to any given place of employment can only be discovered through adjudication.

The National Labor Relations Act was amended in 1974 to cover non-profit health care institutions. Act of July 26, 1974, Pub. L. No. 93-360, 88 Stat. 395. Although Congress expressed concern about the potential for proliferation of health care units in its now hotly debated "admonition," Section 9(b) itself was not changed. Congress did not disturb its nearly thirty-year old conclusion that a case-by-case method be used to determine bargaining units.[1] As Board member Johansen noted:

> Had Congress intended that the Board abandon the decisional approach and utilize a wholly new procedure for determining appropriate units in the healthcare industry, Congress would have told us so explicitly. It did not. Nor did it even implicitly suggest such action.

NLRB, *Collective-Bargaining Units in the Health Care Industry; Second Notice of Proposed Rulemaking*, 53 Fed. Reg.

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[1] In 1973, Senator Robert Taft, Jr. introduced a bill which would have created a health care exception to Section 9(b) and mandated four health care bargaining units (plus the statutory guard unit). S. 2292, 93d Cong., 1st Sess. (1935). The bargaining unit approach proposed in this bill was later abandoned by Senator Taft, who thereafter supported the bill which became law on July 26, 1974. The information gleaned from public hearings and Congressional debates convinced Senator Taft and a majority of his Congressional colleagues that the flexible approach mandated by Section 9(b) was as applicable to health care institutions as it has been to all other covered employers.

33900, 33935 (1988) (Johansen, M., dissenting) (hereinafter referred to as "NPRII").

D. The Board's Reliance Upon Its History Of "Rulemaking" Is Misplaced

In NPRII, the two-member majority contended that formal rulemaking was surely permissible because it "has long been the Board's practice to formulate 'rules' to guide it." NPRII, 53 Fed. Reg. at 33901. This assertion is a half-truth. The precedent cited by the Board majority ("Excelsior" rule; "Peerless Plywood" rule)[2] simply does not support the majority's proposed course of action, because the aforementioned "rules" evolved through the process of case-by-case adjudication. Rather than being "rules" in the sense of the Administrative Procedure Act (hereinafter referred to as "APA") (5 U.S.C. § 553(c)), these cited "rules" merely represent the evolution of guiding precedent.[3] In contrast, the present Rule would freeze the evolutionary process

The majority also contended that rulemaking is authorized under Section 9(b) by citing the various opinions in *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759 (1969).[4]

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[2] NPRII, 53 Fed. Reg. at 33901.

[3] As with all evolutionary processes, adjudicatory "rules" are subject to constant analysis and frequent change. For example, the craft severance "rule" has been re-examined and modified repeatedly. *Compare American Can Co.*, 13 NLRB 1252 (1939) *with National Tube Co.*, 76 NLRB 1199 (1948) *with Mallinckrodt Chemical Works*, 162 NLRB 387 (1966).

[4] NLRB, *Collective Bargaining Units In The Health Care Industry; Final Rule*, 54 Fed. Reg. 16336, 16338 (1989) (hereinafter referred to as "Final Rule Comments").

In *Wyman-Gordon*, however, the Supreme Court was not addressing bargaining unit formulation. The Board has the undoubted authority to make APA-style rules in many areas; however, the language of Section 9(b) does not permit the Board prospectively to establish or prohibit specific unit determinations. The Board should and must continue to determine appropriate units on a case-by-case basis.

Finally, the Board in its Final Rule Comments[5] and the appellate court itself[6] rely upon this Court's opinion in *Heckler v. Campbell*, 461 U.S. 458 (1983), to support their conclusion that the Board may use rulemaking to foreclose individualized unit determinations. *Heckler*, however, is distinguishable because of at least two significant points. First, the provisions of the Social Security Act at issue in *Heckler* explicitly directs the agency to adopt rules to "provide for the nature and extent of proofs and evidence" in hearings. 42 U.S.C. § 405(a). In sharp contrast, the National Labor Relations Act contains the restrictive language of Section 9(b). Second, the rules reviewed in *Heckler* simply establish the national availability of certain types of jobs and therefore do not restrict a claimant's right to establish that he or she has a certain type or degree of disability. Again, in contrast, the Board's Rule virtually converts an employer into a passive participant at a hearing, preordaining the result.

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[5] 54 Fed. Reg. at 16338.

[6] 899 F.2d at 655-56.

III. ESTABLISHING BARGAINING UNITS BY RULEMAKING WILL MAKE THE HEALTH CARE INDUSTRY LESS EFFECTIVE AND EFFICIENT

Bargaining unit determination by means of formal rules is a hazardous and risky notion, which well may endanger all who must rely upon this country's health care system for survival. The health care industry is in an unprecedented state of ferment. With the explosion of health care costs in the past decade, it is obvious that hospitals need the maximum latitude possible to develop and to experiment with organizational structures in an effort to deliver effective and efficient health care. It therefore seems equally obvious that the health care industry ought not to be fettered by administrative shackles. Health care is not something we can simply do without if it becomes too expensive. Despite this glaring need, the Board is seeking to adopt a course of action that will permit rigid groups of rule-defined empioyees to compel bargaining, without respect to the needs of a given hospital, its patients or its community. Bargaining unit rulemaking will virtually destroy the ability of hospitals to evolve and adapt.

Although an "extraordinary circumstances" exception is embodied in the Rule, the Board has made quite clear the fact that the use of the exception "will be rare" and that a "heavy burden" will be upon the party seeking to use the exception. NPRII, 53 Fed. Reg. at 33933. In fact, the Board stated in NPRII that "there will be no units found appropriate besides those permitted in the final

rules." 53 Fed. Reg. at 33905.[7] Thus, preordained rule-made units will be the only units permitted and a hospital will be required to bargain within the parameters of those units no matter what type of organizational structure it might seek to evolve. The advent of such rules will freeze hospital organizations and compel hospitals to organize their workforces in a manner that conforms to the preordained units.

IV. THE RULE CREATING EIGHT HOSPITAL BARGAINING UNITS IS ARBITRARY AND CAPRICIOUS

A. Introduction

After a review of the statutory language, the guiding legislative history and the intent of the 1974 health care amendments, it is our firm conclusion that rulemaking may not be used in the determination of health care bargaining units. While we are in full accord with the argument and conclusions of the American Hospital Association in this regard, we also believe it is appropriate (and hope it will be helpful to the Court) to comment critically with respect to three of the units that the Board has established in the Rule. Those three units are the registered nurse ("RN") unit, the physician unit, and the skilled maintenance unit.

The standard of review applicable to administratively promulgated rules was described by this Court in *Motor Vehicle Manufacturers Association v. State Farm Mutual*

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[7] Reaffirmed in Final Rule Comments, 54 Fed. Reg. at 16345.

Automobile Insurance Co., 463 U.S. 29 (1983), where the Court declared:

> Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

Id. at 43. We submit that the arguments and logic underlying these three proposed units are so implausible that the Rule cannot stand.

B. The RN Unit Is Inappropriate

In NPRII[8] and its Final Rule Comments,[9] the Board set forth several conclusions that, it contends, support the RN bargaining unit. The Board concluded that "nurses are unique" in several respects. The aspect of this so-called "unique" profession most heavily emphasized by the Board is that the RN profession demands continuous interaction with patients.[10] With whom, one might ask, does the Board think that physical therapists, recreational therapists, speech therapists and occupational therapists continuously work? As is all too apparent, they work with patients, each providing their specialized type of care to patients just as nurses provide nursing care. The

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[8] 53 Fed. Reg. at 33911.

[9] 54 Fed. Reg. at 16340.

[10] Final Rule Comments, 54 Fed. Reg. at 16341.

duties of these categories of professional employees demand every bit as much "continuous" interaction with patients as do nurses' duties.

The Board also contends that nurses are unique and require a separate bargaining unit because they are primarily supervised by nurses. NPRII, 53 Fed. Reg. at 33911. Once again, the facts do not support the conclusion. Pharmacists are supervised by pharmacists. Laboratory technologists are under the supervision of a director of medical laboratories. On the nonprofessional side, just as nurses are supervised by nurses, food service workers and housekeepers are supervised respectively by food service managers and housekeeping managers. The fact that a director of nursing supervises nurses is neither unusual nor even significant, in that directors of nursing also supervise nonprofessional employees such as nurse aides and ward clerks, technical employees such as licensed professional nurses, and clerical employees such as ward clerks. Contrary to the Board's implication, nurses are not segregated by the organizational systems within hospitals. They are part of an overall complex web of patient care. Ironically, the Rule promotes the organizational segregation of nurses.

The Board stressed its conclusion that the interaction between nurses and other professional groups is neither constant nor regular. NPRII, 53 Fed. Reg. at 33912; Final Rule Comments, 54 Fed. Reg. at 16341. Although this point is refuted by the record,[11] even if true it

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[11] See, for example, Comment S-1375, filed by The Greater Cincinnati Hospital Council with the Board (October 14, 1988),

(Continued on following page)

would not support the Board's effort to segregate RN's. Other professional groups do not work constantly and regularly with each other. Pharmacists, laboratory technologists and physical therapists will only occasionally interact at a professional level. Nevertheless, the Board deemed it prudent to combine these disparate groups into a single bargaining unit. Now, ironically, the alleged fact that RN's may not interact regularly with other professionals is utilized as justification not to include the RN's in a common bargaining unit. Thus, the Board takes a single principle – the lack of interaction – and uses it to group RN's together and then, without blinking, spins about and deems the same principle irrelevant to its decision to group other non-interacting professional classifications into a single bargaining unit.

The underlying and fundamental flaw with the Board's approach of segregating RN's from other professionals is its assumption that RN's are in fact unique. RN's are important, but not unique in any fashion. RN's, like all other hospital professionals, possess specialized training that prepares them for their particular role in the team delivery of health care to patients. RN's, like many types of professionals, work directly with patients; however, other professionals, such as laboratory technologists and pharmacists, tend to work with materials and

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which recites examples of integrated professional teams. "Examples of integration of professional responsibilities within hospitals are numerous, *as they have come to represent the norm.*" *Id.*, at p. 3 (emphasis added).

substances that are as directly related to patient care as is the hands-on care that nurses and professional therapists provide.

The interaction of RN's with other professionals in patient care might be analogized to a wheel. Nurses coordinate and administer treatments usually prescribed by or prepared by other professionals. RN's are the hub of the professional administration of medical care. The Board now seeks to dismember the wheel. In substance, the Board would pull the spokes of the wheel out and throw them into one bargaining unit, while placing the hub in a different unit. The end result of this approach, not to overstrain the analogy, will be to cause the wagon to break down. The professionals work together as a coordinated unit, often using RN's as the mechanism for coordination. To dismember this team would be unconscionable.

C. The Physician Unit Is Not Warranted

The rationale underlying the creation of a separate unit of physicians is even thinner than the rationale for the RN unit. The same fallacious factors relied upon for RN's are trotted out on behalf of a separate physician unit: physicians are supervised by physicians; physicians have a different role in the health care system than other professionals; physicians have unique interests. Every professional group has concerns unique to itself. Need it even be said that any group of employees that has specialized training, a common educational degree, and particular and identifiable duties will have special concerns that arise from those unique characteristics? But if that is the controlling issue, then the Board's logic compels it

to extend separate units to each identifiable professional group: e.g., a unit for pharmacists; a unit for occupational therapists; a unit for laboratory technologists. None of the union representatives that testified proposed such a ludicrous course of action.

An honest assessment of the Board's reasoning here is that the Board has simply plucked certain facts from the records, sometimes accurately and sometimes not, and used the facts to justify separate units for RN's and physicians, and then ignored the existence of those same facts with respect to the other professions that the Board consolidated in a single unit. One obvious example is the Board's statement that physicians would be outnumbered by nurses at a ratio of 15 to 1. One must ask, so what? Many other professionals exist in small numbers within a hospital, but nevertheless will be included in a consolidated unit. Yet, the Board does not rely on the small number of pharmacists relative to RN's to establish a separate unit for pharmacists. This factor is completely irrelevant and the conclusion that the Board reached is specious. No valid reason was suggested by the Board in its NPRII or its Final Rule Comments for separating RN's, and even less reason exists for separating physicians. A single consolidated professional unit will best serve the interests of patients, who are the most important element of this process, and will meet the statutory requirements of the Act.

D. The Asserted Reasons For Establishment Of A Separate Skilled Maintenance Unit Are Implausible

In the fourteen years of litigation involving the health care industry, the Board has taken a multitude of

approaches to determine the appropriateness of one or another particular type of petitioned bargaining unit. Although neither time nor space permits an encyclopedic description of each of those approaches, it is safe to say that the Board has *never* held that a skilled maintenance unit is automatically appropriate in the health care setting.[12] In its initial *Notice of Proposed Rulemaking*, 52 Fed. Reg. at 25142, the Board conceded that the approval of a separate skilled maintenance unit would be difficult to defend in contrast to its refusal to permit the establishment of "other small units of specialized employees." The Board further noted that the establishment of such units, which would be small in absolute and relative terms to other units within a hospital, would be contrary to the admonition to avoid undue proliferation of bargaining units. *Id*. Now, in a stunning about-face, apparently succumbing to the pressure of the AFL-CIO, the Board's Rule establishes a skilled maintenance unit.

In support of this position, the Board cited several factors which, upon analysis, simply do not support its conclusion. For example, the Board stated that "skilled maintenance employees frequently have their own supervision." NPRII, 53 Fed. Reg. at 33921. One might note without contradiction that numerous classifications of employees within a hospital have their own supervision. Food service employees, housekeeping employees,

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[12] *Compare Shriners Hospitals*, 217 NLRB 806, 808 (1975) *with The Jewish Hospital Association*, 223 NLRB 614, 616 (1976) *with St. Francis Hospital [II]*, 271 NLRB 948, 954 (1984) (In the context of a proposed maintenance unit, the Board warned that "no unit is *per se* appropriate.")

central service employees, admitting employees, laboratory employees, and virtually every other group within a hospital that can be identified as a group has its own supervision. This factor is absolutely lacking in any substantive content. Similarly, finding that skilled maintenance employees have contact with virtually every other employee in the hospital, the Board concluded that a separate unit is justified because these contacts are relatively brief and limited. *Id*. Many service employees travel throughout a facility and have frequent, brief contacts with other service employees (e.g., housekeeping, food service employees, EKG technicians). The Board does not propose to permit, for example, an EKG unit. How can the fact that a skilled maintenance employee has brief and limited contacts with many other employees serve as a justification for separating that skilled maintenance employee into a different unit? The all too obvious answer is that it presents no justification whatever.

In a transparent effort to minimize the unit proliferation problem, the Board points out that no other labor organizations have sought small units. NPRII, 53 Fed. Reg. at 33922. This simple statement reveals the real motive behind the Board's proposal concerning the separate maintenance unit. The Board's real motive is parallel to the motive behind the proposed establishment of a separate RN unit. Where a labor organization has sought out a particular group of hospital employees for representation in this rulemaking procedure, the Board has succumbed to that request. Just as the American Nurse Association ("ANA") successfully persuaded the Board to carve out RN's in order to serve the interests of the ANA, the skilled trades unions have successfully persuaded the

Board to carve out a maintenance group that they wish to represent. Perhaps the health care industry should be thankful that the Hotel & Motel Workers Union did not seek a housekeeping unit; that the United Food and Commercial Workers did not seek a food service unit; that the Teamsters Union did not seek to represent the patient transport workers; or that the International Union of Electricians did not seek to represent the electrocardiogram operators within a hospital.

The grim humor of this analysis should not obscure the fact that the establishment of a separate maintenance unit, like the establishment of a separate RN unit, is not based upon the testimony or evidence acquired in this rulemaking procedure, but is based upon the extent of organizational interests of particular unions and nothing more than that.

V. CONCLUSION

In sum, we cannot emphasize too strongly the graveness of the error which would be established by the implementation of bargaining unit rules. No other covered industry is as important to this country as the health care industry. Yet, in no other industry has the Board considered the pre-definition of bargaining units without regard to the facts and circumstances of particular employment settings. Not only is rulemaking wrong as a matter of law, it is wrong as a matter of judgment with regard to the health care industry. We ask the Court to direct the Board to abandon this course and to return to

the disparity of interest test and the two regular bargaining units which ordinarily would flow from the application of such a test. The GCHC therefore urges the Court to reverse the decision of the Court of Appeals for the Seventh Circuit and direct that the case be remanded to the United States District Court for the Northern District of Illinois with instructions to reinstate the permanent injunction originally issued by that trial court on July 25, 1989.

Respectfully submitted,

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